Docket No. 21-0830

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Robert D. Toler
Plaintiff Below/Petitioner,

v.

Cornerstone Hospital of Huntington, LLC
Defendant Below/Respondent.

From the Circuit Court of
Cabell County, West Virginia
Civil Action No. 19-C-196

BRIEF OF RESPONDENT, CORNERSTONE HOSPITAL OF HUNTINGTON, LLC

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RESPONSE TO PETITIONER'S ASSIGNMENTS OF ERROR

Petitioner asserts the following assignments of error:

1. The trial court erred in broadening the West Virginia Peer Review Privilege beyond its scope to cover a non-patient premises liability accident.

2. The trial judge erred in sustaining Defendant's objection to witness "opening the door" to the incident report.

The Circuit Court of Cabell County (the "Circuit Court") did not commit error in concluding that the incident report created following Petitioner's fall ("Incident Report") was privileged and protected from disclosure pursuant to West Virginia's Health Care Peer Review Organization Protection Act, W. Va. Code § 30-3C-1, et seq., commonly known as the "Peer Review Statute." The lower court did not "broaden" the privilege afforded by the Peer Review Statute. The Incident Report was protected from discovery and, therefore, inadmissible because it was created by a peer review organization and used in a manner consistent with the Peer Review Statute.

Additionally, the lower court was correct in sustaining Cornerstone's objection to Petitioner's counsel's attempt to question Cornerstone's corporate representative at trial about whether an incident report was prepared. Cornerstone did not "open the door" to questioning regarding the Incident Report.[1]

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[1] Petitioner's Notice of Appeal also identified two additional assignments of error that were not acknowledged or argued in his Brief. Any assignments of error not asserted in Appellant's final brief have been deemed waived by this Court. *State v. Potter*, 197 W. Va. 734, 747 n. 13, 478 S.E.2d 742, 749 n. 13 (1996) ("Although the defendant raised additional issues in his petition for appeal, we refuse to address those issues because he did not reassert them in his final brief before this Court."); Syl. Pt. 6, *Addair v. Bryant*, 168 W. Va. 306, 284 S.E.2d 374 (1981) ("Assignments of error that are not argued in the briefs on appeal may be deemed by this Court to be waived."); *see also Wilson v. Kerr*, No. 19-0933, 2020 WL 7931150, *3 (W. Va. 2020) (memorandum decision) (dismissing appeal in its entirety where petitioner's brief failed to list assignments of error).

STATEMENT OF THE CASE

A. Factual Background

Cornerstone Hospital of Huntington, LLC ("Respondent" or "Cornerstone") is a long-term acute care hospital that provides medical care and treatment for seriously ill patients. ***App. 67 (268:8–16)***. Petitioner's long-term girlfriend was admitted to Cornerstone in January 2019 following multiple strokes leaving her paralyzed on one side. ***App. 49 (Tr.194:9–22).*** Petitioner stayed at her bedside around the clock to assist with her care. ***App. 49 (Tr. 194:21–195:3)***.

Petitioner brought this action against Cornerstone over an alleged slip and fall incident that occurred in his girlfriend's room at Cornerstone on January 7, 2019. Petitioner claims that while he was rising out of the reclining chair that he slept in during the night he stepped on a roll of medical tape causing him to fall. ***App. 49 (Tr. 195:4–196:14)***. Petitioner's suit against Cornerstone was filed in May 2019.

Two Cornerstone nurses, Crystal Burgess, RN, and Tammy Jividen, RN, checked on Mr. Toler following the fall while he was still on the floor. At trial, Nurse Burgess testified that Petitioner told her that "I just get Charley horses" and did not need assistance getting up. ***App. 82 (Tr. 326:1-17)***. Likewise, at trial, Nurse Jividen testified that Petitioner told her that he had a "Charley horse" and that he would "get up in a minute." ***App. 71 (Tr. 283:20–284:4)***. Nurse Burgess and Nurse Jividen both testified that Mr. Toler did not mention anything to them about a roll of tape, or that a roll of tape caused his fall. ***App. 82 (Tr. 326:18–327:1); App. 75 (Tr. 297:23–298:6)***.

Nurse Jeff Hall was the house supervisor at Cornerstone in January 2019. ***App. 84 (Tr. 333:9–13***). As house supervisor, he was responsible for coordinating with nursing staff and physicians, addressing family and patient concerns, and for conducting interviews and

investigations related to non-routine events that may require some type of corrective action by the hospital. ***App. 84 (Tr. 333:14–24; 336:6–17)***. Upon his arrival at Cornerstone on the morning of January 7, Nurse Burgess notified Nurse Hall that Petitioner had fallen in the patient's room. ***App. 84 (Tr. 336:6–17)***. Shortly thereafter, Nurse Hall went to the room to investigate and interview Petitioner. *Id.* Nurse Hall testified that Petitioner told him that he "thought it was a Charley horse." ***App. 84–85 (Tr. 336:24–337:13)***. Petitioner did not say anything to Nurse Hall about a roll of tape, or a roll of tape causing the fall. ***App. 85 (Tr. 337:14–22)***.

After the fall, Petitioner was taken to the emergency department at St. Mary's Medical Center ("St. Mary's"). ***App. 51 (Tr. 203:5–204:6)***. While at St. Mary's, Petitioner received treatment from multiple, unbiased medical providers, none of whom made any reference to a roll of tape causing Petitioner's fall in their medical records. For instance, the note prepared by Nurse Donna Kitchens, an emergency room nurse, noted that Petitioner was "[n]ot sure what he hit or why he fell" and gave no indication that a roll of tape caused the fall. ***App. 79 (Tr. 313:4–10, 313:23–315:6)***. Francesca Karle, a Physician Assistant, testified that according to her records, when she asked petitioner what caused him to fall, he told her "my legs gave out causing me to fall on my right side" and made no mention of a roll of tape causing his fall. ***App. 78–80 (Tr. 310:18–21; 316:6–318:6)***. Dr. Oluwakemi Adeyeri, a hospitalist physician, reviewed her medical records and found no references to a roll of tape; instead, her documentation reflects that when she asked Petitioner what caused him to fall, he said he felt like his "legs gave out from underneath him." ***App. 109 (Tr. 436:24–437:17)***.[2] Lastly, Dr. Damian Silbermins, an oncologist consulted for Petitioner's ongoing cancer treatments, testified that according to his notes Petitioner made the following statement when discussing what caused him to fall: "my legs must

[2] Dr. Adeyeri's was deposed by video on July 23, 2021. Dr. Adeyeri's deposition was played for the jury in its entirety by Cornerstone during trial. The text of Dr. Adeyeri's deposition was not captured in the official trial transcript contained in the Appendix submitted to this Court.

have gave away from me." ***App. 87–89 (Tr. 348:1–9, 349:13–17; 352:6–353:1)***. Dr. Silbermins' testified that Petitioner's last chemotherapy treatment had been on January 3, 2019—four days before the subject incident—and that the chemotherapy agents used in Petitioner's treatment could cause weakness, fatigue, and joint pain. ***App. 89 (Tr. 353:8–355:5).***

There is a complete absence of reference to a roll of tape being the cause of Petitioner's fall in the contemporaneously made medical records of these multiple unbiased health care providers.

B. Procedural History

During discovery, Petitioner served written discovery seeking discovery of any reports or other documents relating to the matter. The Incident Report falls within the scope of that request and Cornerstone objected to production of the Incident Report on the ground that it is protected from disclosure by the Peer Review Statute. Cornerstone also filed a privilege log disclosing the existence of the report and the basis for its privilege claim. *See Cornerstone's Response in Opposition to Plaintiff's Motion to Compel Responses to Plaintiff's Interrogatories, Requests for Production* and accompanying exhibits. ***App. 188, 190, 216.*** Petitioner moved to compel production of the Incident Report, but the Circuit Court denied Petitioner's motion, concluding that the Incident Report was not subject to discovery and not admissible pursuant to the Peer Review Statute. ***App. 241–45.***

Prior to trial, Cornerstone moved *in limine* to preclude any reference to Cornerstone's Incident Report. ***App. 293–95.*** Petitioner did not oppose the motion *in limine* and the motion was granted. ***App. 301.***

At trial, Petitioner sought to preclude Nurse Hall from testifying regarding his communications with Petitioner because Petitioner would not be able to use the Incident Report

for cross-examination. ***App. 84 (Tr. 334:15–335:6)***. Cornerstone opposed Petitioner's objection arguing that the discussions between Petitioner and Nurse Hall were not protected by the Peer Review Statute due to the original source exception. ***App. 84 (Tr. 335:7–17)***. The circuit court overruled Petitioner's objection and permitted Nurse Hall to testify regarding the original source information (i.e., his communications with Petitioner). ***App. 84–85 (Tr. 336:1–337:22)***.

Finally, Petitioner argued that Cornerstone's corporate representative, Nurse Brandon Gagnon, "opened the door" to evidence about the Incident Report when Petitioner's counsel questioned him regarding Cornerstone's housekeeping records. ***App. 65–66 (Tr. 257:19–262:24)***. Petitioner's counsel questioned Nurse Gagnon as to whether water on the floor causing a fall would be documented on the housekeeping record, or where it would be documented. Nurse Gagnon acknowledged that something like water on the floor causing a fall may be documented through an "incident reporting process." ***App. 66 (Tr. 263:1–264:2)***. Petitioner's counsel then attempted to open the door to the Incident Report by asking Nurse Gagnon if that was done in this case. Cornerstone objected and the lower court sustained the objection, ruling that Petitioner could not question Nurse Gagnon regarding whether an incident report was generated as a result of this event. ***App. 66 (Tr. 264:2–24)***.

SUMMARY OF ARGUMENT

The Circuit Court correctly ruled that the Incident Report is protected from discovery and inadmissible pursuant to the Peer Review Statute. It is immaterial that Petitioner's claim was for premise liability and that he was not a Cornerstone patient at the time of the fall. In point of fact, the record is clear that the Incident Report was prepared by and for a peer review organization (i.e. Cornerstone) for the sole purpose of improving the quality and delivery of health care, and it was used exclusively by Cornerstone's peer review committees. Under these circumstances, the

Incident Report is clearly privileged, and the Circuit Court correctly shielded it from discovery and excluded it from trial.

Additionally, the Circuit Court did not err by permitting Nurse Jeff Hall, the preparer of the Incident Report, to testify regarding his personal interactions with Petitioner following the subject fall. While the Incident Report itself is confidential and shielded from disclosure, the communications between Hall and Petitioner are not privileged pursuant to the original source exception. Furthermore, Petitioner was not prejudiced by Nurse Hall's testimony as he was given a fair opportunity to cross-examine Nurse Hall regarding his discussions with Petitioner.

Moreover, contrary to Petitioner's argument, Cornerstone did not introduce testimony that "opened the door" to evidence of the Incident Report. Nurse Gagnon did not offer any testimony indicating that an incident report was actually prepared for the subject incident. Nurse Gagnon's reference to an "incident reporting process" was in response to a hypothetical question asked by Petitioner's counsel. It is disingenuous for Petitioner to argue that his lawyer's question constituted "an opening of the door" by Cornerstone.

Finally, even if this Court finds that the Incident Report is not privileged, the exclusion of the Incident Report was, at most, harmless error and not grounds for reversal. With or without the Incident Report, the overwhelming weight of the evidence demonstrates its exclusion did not affect the outcome of the trial.

For these reasons, this Court should affirm the Final Order of Judgment on Jury Verdict entered in favor of Cornerstone on September 14, 2021.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Oral argument is not necessary for the Court to rule on the appeal of this matter.[3] The facts and legal arguments are adequately presented in the briefs and record on appeal, and the decisional process would not be significantly aided by oral argument. The case is appropriate for a memorandum decision. *See Richmond v. Clyde's Floor Covering,* No. 17-0149, 2018 WL 565539, *1 (W. Va. Jan. 25, 2018) (memorandum decision) (entering memorandum decision without oral argument after finding "upon consideration of the standard of review, the briefs, and the record presented, no prejudicial error and no substantial question of law").

STANDARD OF REVIEW

"It is well settled that a trial court's rulings on the admissibility of evidence, 'including those affecting constitutional rights, are reviewed under an abuse of discretion standard.'" *In re C.B.*, 865 S.E.2d 68, 75 (W. Va. 2021) (quoting *State v. Kennedy*, 229 W. Va. 756, 763, 735 S.E.2d 905, 912 (2012)).

ARGUMENT

I. THE CIRCUIT COURT DID NOT COMMIT ERROR IN FINDING THAT CORNERSTONE'S INCIDENT REPORT IS PRIVILEGED AND PROTECTED FROM DISCLOSURE PURSUANT TO WEST VIRGINIA CODE § 30-3C-3.

The Peer Review Statute was enacted by the Legislature to improve the quality of medical care in West Virginia. *See Daily Gazette Co. v. West Virginia Bd. of Medicine*, 177 W. Va. 316, 322, 352 S.E.2d 66, 71 (1986); *Young v Saldanha*, 189 W. Va. 330, 334, 431 S.E.2d. 669, 673 (1993). Pursuant to the statute, peer review is defined as "the procedure for evaluation by health care providers of the quality, delivery, and efficiency of services ordered or performed by other health care professionals." W. Va. Code § 30-3C-1. As this Court has previously

[3] While Petitioner argues that oral argument is necessary, he does not state whether the case should be set for oral argument pursuant to Rule 19 or Rule 20 of the West Virginia Rules of Appellate Procedure, as required by W.Va. R. App. P. 10(c)(6). Respondent disagrees with Petitioner's contention.

explained, "[t]he purpose of [peer review legislation] is not to facilitate the prosecution of malpractice cases. Rather its purpose is to ensure the effectiveness of professional self-evaluation by members of the medical profession, in the interest of improving the quality of health care." *Daily Gazette*, 177 W. Va. at 322, 352 S.E.2d. at 72 (quoting *Jenkins v. Wu*, 102 Ill.2d 468, 479–80, 468 N.E.2d 1162, 1168–69 (Ill. 1984)); see *Young*, 431 S.E.2d. at 673. Ultimately, "the peer review privilege represents a legislative choice between medical staff candor and the plaintiff's access to evidence." *State ex rel. Shroades v. Henry*, 187 W. Va. 723, 727, 421 S.E.2d. 264, 268 (1992).

The legislative-imposed protection set forth by the peer review statute evinces the position that self-policing of the medical community is vital, and the failure to protect the confidentiality of peer review would have a "chilling effect" on such proceedings. *See generally Young*, 189 W. Va. at 334–35, 431 S.E.2d at 673–74. The privilege has been widely recognized and adopted. By the early 1990s, all fifty states and the District of Columbia had recognized and codified the peer review privilege that had been generally recognized under common law. *See Young*, 189 W. Va. at 334, n. 7, 431 S.E.2d at 673, n. 7 (citing 3 Miles J. Zaremski & Louis S. Goldstein, *Medical and Hospital Negligence,* § 44A:07 n. 1 (Callaghan 1990)).

The Peer Review Statute provides absolute protection to "any document prepared by or on behalf of a health care provider for the purpose of improving the quality, delivery or efficiency of health care." W. Va. Code § 30-3C-3(a). Pursuant to the statute, Cornerstone's Incident Report must remain "confidential and privileged" and must "not be subject to discovery in a civil action or administrative proceeding." *Id.*

This Court has previously outlined the procedure for determining whether a particular document is protected by the Peer Review Statute:

> To determine whether a particular document is protected by the peer review privilege codified at W. Va. Code § 30–3C–3 (1980) (Repl. Vol. 2015), a reviewing court must ascertain both the exact origin and the specific use of the document in question. Documents that have been created exclusively by or for a review organization, or that originate therein, and that are used solely by that entity in the peer review process are privileged. However, documents that either (1) are not created exclusively by or for a review organization, (2) originate outside the peer review process, or (3) are used outside the peer review process are not privileged.

Syl. Pt. 1, *State ex rel. Wheeling Hosp., Inc. v. Wilson*, 236 W. Va. 560, 782 S.E.2d 622 (2016); *see also id.* at 570, 632 ("It goes without saying that documents using data that is generated exclusively for or by a peer review organization for its sole use are protected by the peer review privilege.").

Like countless other medical facilities covered by the Peer Review Statute, Cornerstone developed and implemented an event reporting process to promote continual performance improvement in its health care practices. This process is used to identify and minimize hazards not only to patients, but also to visitors and employees, through an investigation, evaluation and analysis of non-routine adverse events. The event reporting process is initiated and completed by and for Cornerstone's peer review committees to safeguard and improve medical care and hospital services and, therefore, falls squarely within the protection afforded by the Peer Review Statute.

A. The Incident Report was prepared by and for a peer review organization.

West Virginia Code Section 30-3C-1 defines a "review organization" as "any committee, organization, individual, or group of individuals engaging in peer review . . . to gather and review information relating to the care and treatment of patients for the purposes of: (i) Evaluating and improving the quality of health care rendered; (ii) reducing morbidity or mortality; or (iii) establishing and enforcing guidelines designed to keep within reasonable

bounds the cost of health care." The statute specifically recognized that a hospital or other healthcare facility may form various types of peer review committees. See W. Va. Code § 30-3C-1.

Cornerstone's incident reports are created to document unexpected events involving patients, visitors, or staff that depart from the ordinary activities of the hospital. Peer review investigations, and the incident reports generated from such investigations, are used to identify and minimize hazards to patients, visitors and employees through an evaluation and analysis of such events. Such reports are prepared by licensed health care professionals and provided only to the Unit/Department Managers, the Director of Quality Management, and the Quality Improvement Committee. The reports are used exclusively by these individuals and committees for evaluating the quality, delivery and efficiency of services ordered or performed at the hospital by other health care professionals and to identify the necessary process improvement initiatives to enhance the quality of care and reduce morbidity and mortality relative to patients, visitors and employees. In other word, these incident reports are used solely for the purpose of quality control and performance improvement.

The Incident Report at issue was created by the House Supervisor, Nurse Jeff Hall, on duty the morning of January 7, 2019. *See* Incident Report, provided under seal to Supreme Court of Appeals of West Virginia; Cornerstone's Supplemental Privilege Log, ***App. 216***. When staff members notified Nurse Hall that Petitioner—a patient's family member who had been staying overnight in the patient's room—had allegedly fallen in the patient's room, Nurse Hall went to investigate. ***App. 84 (Tr. 336:6–17)***. Nurse Hall testified that he interviewed Petitioner for the purpose of determining if some "correction" needed to be made on behalf of the hospital. *Id.*

Nurse Hall investigated the incident and interviewed Petitioner as a "peer review organization" as defined by W. Va. Code § 30-3C-1. Nurse Hall was tasked with conducting this investigation and preparing the Incident Report pursuant to Cornerstone's peer review policy. The Incident Report was provided to the Unit Manager, Director of Quality Management and Quality Improvement Committee and used solely by them to investigate the event and determine whether any change in procedure would be needed to minimize hazards to patients, visitors, and employees and to improve care, treatment, or services ordered and performed at the facility. The Incident Report was maintained by the Director of Quality Management and was not maintained in any medical records, utilized outside of the peer review process, or placed within the public domain. Contrary to Petitioner's assertions, there is no non-privileged source from which to obtain the Incident Report, as it is exclusively controlled and used by the peer review committees and protected from discovery by the Peer Review Privilege.

B. The Incident Report is privileged because it was created by a peer review organization conducting a peer review investigation and was not used outside the peer review process. The facts that Petitioner was not a patient and the claim was for premises liability are immaterial.

West Virginia Code Section 30-3C-3 provides that **"[a]ny document prepared by or on behalf of a health care provider for the purpose of improving the quality, delivery, or efficiency of health care . . . is confidential and privileged and shall not be subject to discovery in a civil action or administrative proceeding."** Nurse Hall, a health care provider, conducted a peer review investigation and prepared the Incident Report for the purpose of improving the quality or delivery of health care and services at Cornerstone. Petitioner's fall was a non-routine event that occurred inside a patient's room and near a patient's bedside. The room was in use by health care professionals for the administration of medical care to a seriously ill patient. Nurse Hall testified that he went to the patient's room and interviewed Petitioner to "see

if it was something . . . that we needed to do a correction on." ***App. 84 (Tr. 336:6–17)***. The investigation was conducted and the findings were recorded for the purpose of improving the quality of care and services at Cornerstone. Accordingly, the Incident Report is covered by the peer review privilege.

Petitioner argues that the circuit court's prohibition on discovery or disclosure of the Incident Report amounts to a "slippery slope" because Petitioner's claim was a premises liability claim and the accident involved a non-patient. These facts are immaterial. The Peer Review Statute is not limited to medical negligence claims, nor is it limited to situations where a patient is directly impacted by a non-routine adverse event. In fact, the statute makes no distinctions in this regard. The key issue is whether a health care provider or health care facility's actions are potentially at issue and, as such, are evaluated by other health care professionals for quality and efficiency.

Petitioner's alleged fall occurred in a patient's room where health care treatment and services were being administered. Nurse Hall, as an integral member of Cornerstone's peer review committee, was tasked with investigating the incident to determine if some aspect of patient care played a role in Petitioner's fall. Depending on the cause of Petitioner's fall, a health care provider's actions could have been involved, and corrective action may have been needed. Contrary to Petitioner's assertions, this incident was clearly distinguishable from a slip and fall at a grocery store or in a parking lot.

When a question exists as to whether certain documents should be protected under the peer review privilege, this Court has previously found that the lower court should hold an *in camera* review to determine whether the privilege applies to the documents at issue. *See Young v. Saldanha*, 189 W. Va. 330, 333, 431 S.E.2d 669, 672 (1993); *State ex rel. Shroades v. Henry*,

187 W. Va. 723, 727–28, 421 S.E.2d 264, 268–69 (1992). Consistent with this precedent, the Circuit Court reviewed Cornerstone's peer review policy and the Incident Report *in camera* and concluded that the Incident Report fell squarely within the parameters of the Peer Review Statute. ***App. 243–44***.

Because the Incident Report is privileged and protected from disclosure by the Peer Review Statute, the circuit court did not commit error in refusing to admit the Incident Report into evidence or allow Petitioner to question Cornerstone's witnesses regarding the existence or content of the Incident Report.

II. THE CIRCUIT COURT DID NOT COMMIT ERROR BY PERMITTING NURSE HALL TO TESTIFY REGARDING HIS DISCUSSIONS WITH PETITIONER AS THE DISCUSSIONS FALL WITHIN THE ORIGINAL SOURCE EXCEPTION TO THE PEER REVIEW PRIVILEGE.

At trial, Nurse Hall was permitted to testify, over Petitioner's objection, regarding his discussions with Petitioner following the fall on the morning of January 7, 2019. Nurse Hall testified that when he asked Petitioner what had happened, Petitioner told him that he "thought it was a Charley horse." ***App. 84–85 (Tr. 336:24–337:13)***. Petitioner did not say anything to Nurse Hall about a roll of tape, or a roll of tape causing the fall. ***App. 85 (Tr. 337:14–22)***.

This testimony from Nurse Hall was admissible. The Peer Review Statute provides that witnesses—including members of peer review organizations—cannot be prohibited from testifying regarding information available from original sources, including information within their personal knowledge. W. Va. Code § 30-3C-3(b); W. Va. Code § 30-3C-5. The statute expressly states that information available from original sources are "not to be construed as immune from discovery or use in any civil action merely because they were included in any report or analysis related to improving the quality, delivery, or efficiency of health care." W. Va. Code § 30-3C-5.

The statements made by Petitioner to Nurse Hall are a prime example of an "original source." The statements Petitioner made to Nurse Hall during this conversation, including Petitioner's comment that he had suffered a "Charley horse" and the absence of any mention of a roll of tape, are not barred as evidence simply because Nurse Hall heard them as part of his peer review investigation.

The personal knowledge of a witness is a type of original source. The Peer Review Statute specifically provides that "[a] person who testifies before a review organization, or who is a member of a review organization, ***shall not be prevented from testifying in court or an administrative hearing as to matters within his or her personal knowledge***." W. Va. Code § 30-3C-3(b) (emphasis added). In accordance with the express language of the statute, the circuit court did not err in permitting Nurse Hall to testify regarding matters within his personal knowledge, specifically, the statements made to him by Petitioner shortly after the subject accident.

Nurse Hall testified that he went to the patient's room and spoke directly with Petitioner regarding the incident. ***App. 84 (Tr. 336:6–17)***. Nurse Hall further testified that Petitioner told him that he had experienced a "Charley horse" and that Petitioner never mentioned anything about a roll of tape or a roll of tape causing his fall. ***App. 84–85 (Tr. 336:24–337:22)***. The Circuit Court was correct in permitting Nurse Hall to testify regarding the details of his conversation with Petitioner as this information falls within the original source exception and was within Nurse Hall's personal knowledge.

Petitioner argues that Nurse Hall should not have been allowed to testify regarding his discussions with Petitioner because Petitioner was not permitted to cross-examine Nurse Hall about the contents of the Incident Report. Petitioner's argument misunderstands the purpose of

the Peer Review Statute. The statute provides that "[a]ll peer review proceedings, communications, and documents of a review organization and all records developed or obtained during an investigation . . . shall be confidential and privileged and shall not be subject to discovery in any civil action or administrative proceeding." W. Va. Code § 30-3C-3(c). The statute does not shield original source information and information within the personal knowledge of members of a peer review organization. *See* W. Va. Code § 30-3C-3(b); W. Va. Code § 30-3C-5.

Petitioner had an opportunity to cross-examine Nurse Hall regarding his conversation with Petitioner following the fall. Furthermore, Petitioner was permitted to offer his own direct testimony regarding not only his discussions with Nurse Hall, but also his conversations with his family members, other Cornerstone personnel, and the health care providers at St. Mary's following the fall. ***The only item of evidence shielded from disclosure was the Incident Report itself.*** The legislature has clearly expressed its intent that the interest of improvement in the quality of health care, and need for candor in peer review investigations which facilitates that improvement, outweighs a plaintiff's right to access such evidence. *See State ex rel. Shroades v. Henry*, 187 W. Va. 723, 727, 421 S.E.2d. 264, 268 (1992).

III. NURSE BRANDON GAGNON DID NOT "OPEN THE DOOR" TO EVIDENCE REGARDING THE INCIDENT REPORT.

Petitioner argues that Cornerstone's corporate representative, Nurse Gagnon, opened the door to questioning regarding the Incident Report during trial. This claim is not accurate. In reality, ***Petitioner's counsel***, not Cornerstone, attempted to open the door to the existence of an Incident Report through a series of questions Petitioner asked Nurse Gagnon relating to Cornerstone's record retention and housekeeping policies:

Q. So you would agree with me that Cornerstone was aware that Robert Toler fell and broke his hip on January the 7th in your room?
A. **We were aware that he fell.**
Q. You don't think it would be prudent to maintain the record that the room was cleaned when you had a serious injury occur in that room?
A. **Depending on the factors of the mechanism of the fall.**
Q. Oh. What does that mean?
A. **For instance, if he would -- if somebody would fall because water was on the floor, then we would need to keep that record. It would be prudent then. But, you know, accidents happen; so you just-- you can't say one way or the other.**
Q. How would you document that there was water on the floor for purposes of maintaining the room cleaning record? Where would you document water? Would it be noted here anywhere?
A. **It would not be.**
Q. Okay. Where would you document that the fall had occurred due to water or some other obstruction on the floor?
A. **It would be documented through an incident reporting process.**
Q. Okay. And was that done in this case?

App. 66 (Tr. 263:1–264:2). Counsel for Cornerstone immediately objected to this last question and a bench conference was held, whereupon the court sustained the objection confirming its prior ruling with respect to introduction of evidence relating to the Incident Report. ***App. 66 (Tr. 264:3–24)***.

Although Petitioner apparently sought to introduce the Incident Report through Nurse Gagnon, this witness did not testify that an incident report even existed for the subject accident. When Petitioner asked Nurse Gagnon how the hospital would have documented evidence that a fall occurred due to "water or some other obstruction on the floor," Nurse Hall only testified, in a hypothetical manner, that the hospital would have engaged in an "incident reporting process" if water or some other obstruction had been identified in the floor. Nurse Gagnon was testifying under oath and any other answer to Petitioner's question would have been untruthful. When Petitioner definitively asked Nurse Gagnon if an incident report existed for the subject incident, Cornerstone objected, and the line of questioning ended.

Petitioner's claim that Nurse Gagnon's utterance of the words "incident report" resulted in an opening of the door wholly misses the mark. None of the testimony offered by Nurse Gagnon in response to the above line of questioning introduced any new evidence into the case. Petitioner's questioning involved Cornerstone's housekeeping practices in the hypothetical scenario that water was found in a patient's room after a fall. These questions had no bearing on the question at issue in this case: whether Petitioner fell because of a roll of tape.

Furthermore, Petitioner's claim that the trial testimony confirmed the existence of an incident report for the jury is not accurate. When the jury submitted a questionnaire to the court during deliberations regarding whether an incident report was prepared and available for review, the first question asked was "Is there an Initial Incident Report?" ***App. 117 (Tr. 466:8–13)***. This question clearly demonstrates that the jury ***did not know*** whether an incident report was created relating to Petitioner's injury.

Petitioner's reliance on the decisions in *State v. Baker*, 230 W. Va. 407, 738 S.E.2d 909 (2013) and *State v. James*, 144 N.J. 538, 677 A.2d 734 (1996) is misplaced. In *Baker*, the lower court had ruled prior to trial that evidence of the defendant's prior convictions and parole status was inadmissible. 230 W. Va. at 411, 738 S.E.2d at 913. The defendant was accused of robbing a store where he had worked and been fired 10 years earlier. *Id.* The prosecution wanted to argue that the reason the defendant had waited so long to seek revenge on his former employer was that the defendant had been in prison during that period for another crime, but was out on parole when this robbery occurred. *Id.* At trial, the prosecution questioned the store owner about the defendant's employment and termination 10 years earlier. *Id.* at 412, 914. During cross-examination, the defendant's counsel asked two questions that merely summarized the information that the prosecution had introduced on direct exam. *Id.* The trial court ruled that this

cross-examination "opened the door" to evidence regarding the defendant's other convictions and parole status. This Court reversed on appeal, finding that the defendant's limited cross-examination did not warrant the admission of the prior convictions or parole evidence. *Id.* This Court found that the defendant's cross-examination was proper and "did not inject anything new into the case," as it was the prosecution, not defendant, who introduced the subject of "time" through its examination of the store owner. *Id.* at 413, 915. Similar to the case at bar, it was ***Petitioner***, not Cornerstone, who may have introduced the subject of the incident report through his questioning of Nurse Gagnon. Cornerstone's counsel did not ask any questions of Nurse Gagnon related to the Cornerstone's incident reporting process or the Incident Report.

The *James* decision concerned a criminal defendant who attempted to introduce evidence regarding a victim's identification of a perpetrator, where the trial court had previously ruled that pretrial identifications were inadmissible due to constitutional violations. *James v. Baker*, 144 N.J. 538, 677 A.2d 742 (1996). The Supreme Court of New Jersey noted that "[t]he doctrine of opening the door allows a party to elicit otherwise inadmissible evidence when *the opposing party* has made unfair prejudicial use of related evidence." *Id.* at 554, 742 (*emphasis added).* By questioning Nurse Gagnon about the existence of an incident report, it was ***Petitioner's counsel***, not Cornerstone, who sought to make an unfair use of the inadmissible evidence.

In short, Nurse Gagnon did not open the door to evidence regarding the Incident Report, and Petitioner's counsel's attempts to question Nurse Gagnon about the Incident Report does not constitute a waiver of Cornerstone's peer review privilege over the document.

IV. IF THE CIRCUIT COURT COMMITTED ERROR IN EXCLUDING EVIDENCE RELATING TO THE INCIDENT REPORT, SUCH ERROR WAS HARMLESS AND NOT REVERSIBLE.

While the circuit court did not commit error in refusing to admit evidence relating to the Incident Report, or in allowing Nurse Jeff Hall to testify regarding original source information within his personal knowledge, these evidentiary rulings, even if incorrect, would not constitute reversible error. As noted in Rule 61 of the West Virginia Rules of Civil Procedure, "[t]he court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties."

The doctrine of harmless error is a "firmly established principle" that guides the exercise of the appellate jurisdiction of this Court. *Whittaker v. Pauley*, 154 W. Va. 1, 6, 173 S.E.2d 76, 79 (1970). This Court has long taken the position that "[e]ven if error exists, we will not overturn a ruling or decision if we find the error was harmless." *State ex rel. Cooper v. Caperton*, 196 W. Va. 208, 215, 470 S.E.2d 162, 169 (1996) (citing W. Va. R. Evid. 103(a); *Reed v. Wimmer*, 195 W. Va. 199, 209, 465 S.E.2d 199, 209 (1995)).

"Error is harmless when it is trivial, formal, or merely academic, and not prejudicial to the substantial rights of the party assigning it, and where it in no ways affects the outcome of the trial." *Reed,* 195 W. Va. at 209, 465 S.E.2d at 209 (finding that trial court's refusal to declare a mistrial following plaintiff's deliberate mention of the word "insurance" during cross-examination did not constitute reversible error). Put another way, "error is prejudicial and ground for reversal only when it affects the final outcome and works adversely to a substantial right of the party assigning it." *Id.*

Each of Cornerstone's employees with knowledge of Petitioner's accident testified that Petitioner said nothing about a roll of tape or a roll of tape causing his fall on January 7, 2019.

App. 75 (Tr. 297:23–298:6); ***App. 82 (Tr. 326:18–21)***; ***App. 85 (Tr. 337:14–22)***. Additionally, the medical providers at St. Mary's who treated Petitioner shortly after the accident, and who asked Petitioner why he fell, documented no mention of a roll of tape. ***App. 79 (313:23–315:6); App. 79–80 (316:6–318:6)***. On the contrary, the medical records from Petitioner's treatment stated that Petitioner's "legs gave out" or that Petitioner was "not sure what he hit or why he fell." ***App. 79 (Tr. 313:4–10, 313:23–315:1)***; ***App. 79–80 (Tr. 316:6–317:14); App. 88 (Tr. 352:6–15)***. Based on the testimony offered at trial, it was eminently reasonable for the jury to return a verdict on behalf of Cornerstone, and Petitioner's substantial rights were not affected by his inability to introduce the Incident Report into evidence or cross-examine Nurse Hall regarding the Incident Report.

In weighing the totality of the evidence before the jury, including the testimony of Cornerstone's employee witnesses, the unbiased statements of Petitioner's post-incident medical providers, and the medical records that provided ***no indication whatsoever*** that a roll of tape caused Petitioner's fall, the lower court's decision not to introduce evidence of the Incident Report, even if incorrect, was harmless error.

CONCLUSION

For the reasons set forth above, Cornerstone prays that Petitioner's appeal be denied, that the Circuit Court of Cabell County's Final Order of Judgment on Jury Verdict be affirmed, and that Cornerstone be awarded its costs on appeal.

Dated: February 25, 2022.

Respectfully submitted,

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Docket No. 21-0830

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Robert D. Toler
Plaintiff Below/Petitioner,

v.

Cornerstone Hospital of Huntington, LLC
Defendant Below/Respondent.

From the Circuit Court of
Cabell County, West Virginia
Civil Action No. 19-C-196

CERTIFICATE OF SERVICE

I hereby certify that on this 25th day of February, 2022, a true and accurate copy of the foregoing ***Brief of Respondent, Cornerstone Hospital of Huntington, LLC*** was served via United States mail, postage prepaid, addressed as follows:

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